A Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children, Adolescents and Their Families

INTRODUCTION

This *2003 Report on the Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children and Adolescents* provides a progress report on the *DMHMRSAS Report on the Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children and Adolescents* submitted in 2002, and additional information on the progress toward the development of the "329-G Policy and Plan" and present proposed recommendations. The information contained in this report will detail the activities, issues, findings, and background of the proposed recommendations of the 329-G Planning Group and associated workgroups for the '02-'03 State Fiscal Year.

Since the implementation of the Comprehensive Services Act in 1993, children's issues have been studied and researched extensively from a variety of perspectives in Virginia, and recommendations have been made to the General Assembly related to improving services for children in many of the resulting research studies and documents. Many of these reports were reviewed and referenced during the development of House Document 23, *Final Report of the Commission On Youth: Youth with Emotional Disturbance Requiring Out-of-Home Treatment.* For your information and review, listed in **Appendix C** are the 20 reports in House Document 23 (HD 23) by reference, with the major outcomes and issues highlighted.

Themes and issues in the documents referenced for HD 23 were consistent with those themes and issues that were brought into discussions during the 329-G Planning Group and workgroup meetings. Some selected main themes related to Budget Item 329-G were:

1) The importance of early identification and early intervention in a community system of care.
2) The need for increased case management.
3) The impact of the reduction of state psychiatric beds for children and adolescents without increased support for alternatives in the community.
4) The distinction between "mandated" and "non-mandated services".
5) The impact of the "mandated" distinction on funding for services.
6) The importance of an increased and improved use of Medicaid .
7) The importance of training, technical assistance and outcome evaluation in developing a system of care.

Since September of 2000 (and the printing of House Document 23), there have been additional related studies completed, with recommendations that the 329-G Planning Group and workgroups found helpful in developing the recommendations found in this report. Those most recent studies are listed below.

YEAR	
2002	*Studying Treatment Options for Offenders Who Have Mental Illness or Substance Abuse Disorders* (HJR142/SJ97 Final Report: Senate Document 25, 2002 General Assembly Session) Joint Commission on Behavioral Healthcare, Virginia Crime Commission and the Virginia Commission on Youth
2002	*A Plan for Improving Services and Containing Costs in the Treatment and Care of Children Under the Comprehensive Services Act for At-Risk Youth and Families*, Secretary of Health and Human Resources

The depth and breadth of research and information gathering over the past years related to CSA and children's issues in general provided a solid foundation on which 329-G activities could take place. These studies and reports provided a wealth of information on historical developments, geographic and population need, costs of implementation of services and systemic considerations relevant to the 329-G Policy and Plan.

WORKPLAN DEVELOPMENT AND ACTIVITIES TO DATE

329-G Planning Group

In order to "provide and improve" access, the Department needed to know what access issues existed in Virginia, and develop recommendations that would address these access issues comprehensively. To accomplish this goal, the 329-G Planning Group sought to gain consensus by initially exploring what an "ideal" system of mental health, mental retardation and substance abuse services for children, adolescents and their families would entail.

In July of 2002, the DMHMRSAS utilized the services of a consultant to assist in defining the role and future work of the 329-G Planning Group for the coming year. Major objectives of this meeting with the consultant were to:

- To develop a vision that will provide a description of the characteristics of an integrated system

- To identify the goal areas around which work will have to be completed to be accomplished in order to make the vision a reality

The meeting summary is attached to this report as **Appendix D** for review. A major product of the meeting was the group's identification of the "characteristics of integrated system for children". The 329-G Planning Group then prioritized areas to work on during the next year. Those areas identified as priority were (highest priority items listed first):

- Restructuring/Rebuilding the system
- Funding issues
- Service needs
- Gaining buy-in from others
- Advocacy for mental health issues
- Education of legislators and others on the need
- Child and family involvement

Following this meeting, the DMHMRSAS created a crosswalk of the characteristics of an integrated system for children and families, by the identified focus areas.
(Appendix E).

In addition to the external meetings, the DMHMRSAS formed an internal planning group to assist in the planning and guidance for 329-G activities. The DMHMRSAS mirrored the overall conceptualization of an "integrated" service continuum of mental health, mental retardation and substance abuse services for children and adolescents with staff from the three disability offices.

One of the initial tasks for the 329-G Planning Group and workgroups during this reporting period was the identification of activities that may already exist or were in development that may support or provide key information for the final recommendations of this report. Those identified activities are listed below by disability area, and are related in context to the task associated with Budget Item 329-G and the final recommendations as they provide support for future activities and the continued movement toward improved access to mental health, mental retardation and substance abuse services for children, adolescents and their families in Virginia.

CONCURRENT ACTIVITIES (SFY '03)

Reinvestment and Restructuring

In December 2002 Governor Warner proposed regional reinvestment projects in five regions. The 2003 General Assembly, in its final budget

deliberations, endorsed the Governor's proposed "Community Reinvestment Initiative," and clearly stated its intent that the Governor and DMHMRSAS continue to work toward restructuring the services system.

The reinvestment projects are, in Governor Warner's words, "the first stage of a multi-year vision to fundamentally change how mental health, mental retardation and substance abuse services in Virginia are delivered and managed…Our long-term goal is to continue progress on moving the system toward community-based care, so that we can help all Virginians to live in our communities with dignity and independence." This goal has been the public policy of the Commonwealth for over two decades.

As part of the planning process special populations workgroups are being planned to address the specific short and long-term needs of forensic, gero-psychiatric, mental retardation, mental retardation/mental illness, child/adolescent, and substance abuse populations. Membership in these special populations groups will include representation from regional partnerships, advocacy groups, consumers, family members, relevant State agencies, public and private providers and other interested parties. The work of the 329-G planning group will be an important source for guiding the child/adolescent special populations group in planning.

The membership of the 329-G Planning Group was represented in many activities this reporting period that were had an impact on the provision and improvement of access by children, adolescents and their families to an integrated system of mental health, mental retardation and substance abuse services. The activities listed below (by disability area) fall within the context and scope of this report as they relate to the overall conceptualization of the need to provide and improve access to mental health, mental retardation and substance abuse services for children, adolescents and their families in Virginia.

Mental Health Activities

The Department of Social Services (DSS) has been preparing for the federal Child Welfare Audit that will take place in Virginia during the week of July 7-12, 2003. One of the components of the audit is a review of access to mental health care for children. The DSS reported that social service policy requires that all children receiving Comprehensive Services Act (CSA) funded services have a uniform assessment of behavior and functioning. CSA uses the Child and Adolescent Functional Assessment Scale (CAFAS) and the Preschool and Early Childhood Assessment (PECFAS). Children in foster care receive Medicaid to access mental health services. Other low-income families may access Medicaid or Family Access to Medical Insurance Services (FAMIS) for mental health services.

The DMHMRSAS receives an annual allocation of state general funds to support the implementation of youth suicide prevention activities associated with the Youth Suicide Prevention Plan (Senate Document 16, 2001 General Assembly Session). The DMHMRSAS has provided support and technical assistance on a statewide basis geared toward the reduction of youth suicide through the development of local prevention programs and supports. A major goal of DMHMRSAS activities is to provide an increased awareness of the risk factors associated with youth who may be at-risk for suicide, including populations at increased risk such as youth with substance abuse disorders and/or depression. The DMHMRSAS is represented on the Virginia Department of Health's (VDH) Intra-agency Suicide Prevention Advisory Council, a group convened by the VDH that is comprised of key state agencies and stakeholders that will be developing an across the lifespan plan for suicide prevention by June of 2004, and provides guidance to the Virginia Department of Health's (Lead agency for suicide prevention efforts in Virginia) activities related to suicide awareness and prevention.

The Secretary of Health and Human Resources, Office of Comprehensive Services, State Executive Councils and the State and Local Advisory Team continue to identify ways to provide and improve services to children at risk of emotional and behavior problems.

DMHMRSAS disseminated a report on therapeutic day treatment programs in Virginia, along with recommendations for development and expansion of programs in Virginia. DMHMRSAS is also collaborating with DOE and Community Service Boards regarding ways to develop and expand day treatment programs in school systems throughout Virginia.

The Department of Education (DOE), Department of Rehabilitative Services (DRS) and DMHMRSAS launched a statewide initiative in FY2003 to strengthen local planning and services for young people with emotional and behavioral disorders who are transitioning into adulthood. The initiative included a pre-conference workshop at the Virginia Transition Forum on March 17, 2003 and four regional community team workshops (April 29 – May 2, 2003). Over 100 people attended the pre-conference workshop and over 230 people enrolled in the regional community team workshops.

In 2003, the Virginia Commission on Youth Submitted the document *Collection of Evidence-Based Treatment Modalities for Children and Adolescents with Mental Health Treatment Needs*. The Commission on Youth has begun to disseminate this document statewide in order to improve services to youth.

DMHMRSAS coordinated quarterly meetings of 4 Community Service Boards targeted toward the enhancement of local evidence-based practice services program development and implementation

During the 2002 General Assembly, legislation was passed (House Bill 887/Senate Bill 426) which directed DMHMRSAS to provide the number of licensed and staffed acute care psychiatric beds and residential treatment beds for children and adolescents in public and private facilities, as well as the actual demand for these beds, to the General Assembly by December 1, 2002. DMHMRSAS now reports this data on a quarterly basis to the Chairmen of the House Appropriations and Senate Finance Committees and the Virginia Commission on Youth.

The Department of Social Services (DSS) and DOE provided intervention training to mandated reporters at public schools regarding child abuse and neglect**.** This training was designed to prepare the mandated reporters for recognizing and identifying any mental health concerns that may be associated or exhibited in concert with a history of child abuse or neglect.

Mental Health and Juvenile Justice Activities

Effective March 1, 2003, all local detention centers began screening juveniles on entry into their facility with the standardized screening instrument entitled the Massachusetts Youth Screening Instrument-Second version (MAYSI-2).

In early 2003, the DMHMRSAS submitted an application for funding through the Department of Criminal Justice Services Juvenile Accountability Incentive Block Grant (JAIBG) funds. The application was successful, and will result in $104,000 in funds to each of five localities toward the provision of mental health and substance abuse treatment services to juveniles in detention. Services to be provided include but are not limited to assessment, crisis, outpatient, and transition discharge planning. Each detention center included in the pilot will have a full-time mental health/substance abuse therapist and a full-time case manager dedicated to their facility to provide needed mental health and substance abuse services, as identified and within the scope of the identified target population.

The Department of Criminal Justice Services made the mental health needs of juveniles a priority for Juvenile Accountability Incentive Block Grant funding and Title II funding for the upcoming fiscal year. As a result, competitive grant opportunities were made available for localities in December 2002.

Advocacy and Parent Activities

During this fiscal year, Voices for Virginia's Children, a statewide, non-profit, non-partisan child advocacy organization, contributed to improving access to mental health care for children in several ways. Leading the 300+ member Virginia Coalition for Children's Mental Health, Voices has served as a connector and catalyst for organizations and individuals across the state working to improve access to mental health services for children. Bringing the voices and experiences of parents to state level decision makers, Voices works directly with legislators and administration officials to make smart and substantive policy improvements, and to make children a priority.

The DMHMRSAS provides $75,000 annually to the statewide Federation of Children's Mental Health Chapter. Parents and Children Coping Together (PACCT) is a statewide organization for families of children with mental, emotional and behavioral disorders operated by parents and family members. During FY 03, PACCT published "Parent Watch", a quarterly newsletter targeted toward an audience of families and providers. Copies of "Parent Watch" were also made available to the 40 Virginia Community Service Boards and the state hospitals serving children and adolescents. PACCT also operates a statewide phone number as a source of information on children's mental health. The numbers (local and toll-free) are on PACCT brochures and stationery, and are distributed on correspondence and during trainings. The support provided by DMHMRSAS also includes mini-grants and technical assistance to new and existing family support groups and networks, providing linkages for families of children with mental, emotional and behavioral disorders. During the most recent quarter, PACCT provided mini-grants of $250 each to the following support groups and networks:

- Asperger Family Support Group
- Teen Mothers
- Ekhart Support
- Helping Hands Support Group

PACCT also offers parents or caregivers (who care for children with mental, emotional and behavioral disorders) a stipend to encourage their attendance at various training events. The stipend is offered to assist parents and caregivers overcome barriers to their participation in the training program.

Substance Abuse Services Activities

DMHMRSAS supports 8 special women's projects including Project LINK, which provided intensive case management and support services to pregnant, postpartum, and "at risk" substance-using women and their

children at 14 CSBs. In SFY 2002, the 8 LINK sites received 1087 referrals and opened 382 new cases on pregnant and parenting mothers.

All CSBs provide outreach, assessment & case management services to hospital-referred, postpartum, substance-using women and their substance-exposed infant who is identified and referred at delivery. In addition to the Project LINK sites, some CSBs provide specialized services for substance using women to promote bonding with their infants and older children, many of whom may also be substance exposed. Substance exposed infants who demonstrate specific neurodevelopmental behaviors may qualify for Part C and are eligible for Early Intervention services.

DMHMRSAS supports the *Commonwealth Partnership for Women and Children Affected by Substance Use (Partnership),* an interagency, cross discipline consortium that serves in an advisory capacity to the Office of Substance Abuse Services. The Partnership meets quarterly to address the service and treatment needs of substance using women and their families and identify strategies for improving service delivery. In 2002, the Partnership introduced an annual training/education event targeted at enhancing services for women and their families. In the fall of 2002, 233 child service providers attended 3 regional one-day trainings, the Impact of Maternal Substance Use on Children coordinated by the Partnership In the fall of 2003, the Partnership will sponsor 3 regional workshops for Women in Recovery.

The DMHMRSAS is planning a 2-day Women's Services Conference for CSB supervisory and clinical staff in the fall of 2003. As part of this conference, OSAS will address the federal requirements to provide "family focused" services and will provide training regarding identifying and addressing children's mental health and substance abuse service needs as part of the parent's treatment.

In conjunction with the Department of Social Services and the Office of the Executive Secretary of the Supreme Court, DMHMRSAS submitted a grant application for technical assistance to the National Center for Substance Abuse and Child Welfare (NCSACW). DMHMRSAS and DSS requested assistance developing an interagency strategic plan that addresses the developmental, cognitive, psychological and health care needs of substance exposed, substance affected, and substance using youth and their families involved in or "at risk" of involvement in the child welfare system. Virginia has been informally notified that it has been selected as a grant recipient and will receive formal notification in June. Additional information should be made available at that time regarding the length and provisions of the grant.

The DMHMRSAS hosted the Prevention Institute II for more than 100 CSB prevention service providers, held a Critical Incident Stress Management Training for professional working with children, and facilitated several one-day training events in grant writing and a prevention data system.

In June 2003, the DMHMRSAS submitted a State Incentive Grant for Persons with Co-Occurring Substance Abuse and Related Disorders to the Substance Abuse and Mental Health Services Administration (SAMHSA).

Mental Retardation Activities

Virginia has been disseminating the statewide Family Survey since late 2000. This information continues to be collected and reviewed so the DMHMRSAS can make informed decisions about improvements to the mental retardation services provided to consumers. The purpose of this grant funded activity is to raise awareness about the need to re-conceptualize early intervention service delivery including putting into practice natural learning opportunities as the way to enhance child and family capacity within the many environments in which they live and learn. Natural learning opportunities expand service delivery away from a single location where an early intervention service is provided to include all places that provide learning and support for children and families.

Phase II: Natural Environments Training: Moving From Theory to Practice trainings have been completed in five of six Health Planning Regions in Virginia. This model of training is intended to develop the capacity of Virginia's Early Intervention stakeholders (including state and local early intervention systems, families, providers, administrators, etc.) to partner in the process of continuous learning and implementation of programming for children, families and communities. The enhancement grant provides Virginia with the opportunity for training for early intervention providers across disciplines in the model of natural learning opportunities.

The second draft of the Virginia Early Intervention Philosophy and Service Guidelines, now titled (Proposed) Philosophy and Considerations for Individualizing Early Intervention Services, has been disseminated to Community Services Board Mental Retardation Directors, Executive Directors, providers and families (through respective council coordinators) for review and feedback. Feedback has also been requested from the individuals who are presenting the Natural Environments Phase II Trainings, as well as from other national consultants.

The DMHMRSAS Office of Mental Retardation, Part C Office staff are in the process of reviewing Development of Infant & Toddler Connection of Virginia Documents in order to determine which continue to be relevant and up-to-date; which need to be revised; which need to be archived; and what new documents are needed. Through this process, care is being taken to ensure that documents are consistent with current research and are also internally consistent.

Members of the Virginia Early Intervention Autism Initiative recently held an educational presentation provided by Bruce Schaffer of New Horizons. Work continues toward the goals of meeting the needs of children with autism spectrum disorders, their families and providers in the Commonwealth.

Medicaid and FAMIS Activities

The 2003 Virginia legislature expanded FAMIS coverage to include community mental health rehabilitative services: case management, intensive in-home services, therapeutic day treatment, and emergency services.

WORKGROUPS

The DMHMRSAS formed four workgroups using the membership of the larger 329-G Planning Group and other invited participants. The workgroups were tasked with addressing specific areas of the Budget Language (as listed below), and reporting back to the larger 329-G Planning Group with recommendations by April 2003. The workgroups were as follows:

- Services needed by children
- Funding restrictions of the Comprehensive Services Act
- Strengths and weakness of the services and administrative structure
- Costs and funding for services

Each workgroup was asked to develop a work plan, including pertinent goals, objectives and strategies, that would best accomplish the recommended components of a mental health, mental retardation and substance abuse services system for children, adolescents and families in Virginia, as related to that particular workgroup's focus area of Budget Item 329-G.

Recommendations from each workgroup were presented to the

329-G Planning Group for consideration and development of final recommendations for inclusion in this report.

It is anticipated that once the recommendations in this report are endorsed, the workgroup recommendations presented below would assist in the action plan toward 329-G implementation.

Services Workgroup

"The plan shall identify the services needed by children"...
-Excerpt from 329-G Budget Language

The services workgroup identified an overarching theme in order to guide their discussions and recommendations:

A continuum of mental health, mental retardation, and substance abuse services is needed to improve access, with case management as the coordinating component for those services.

A "continuum of care" is defined for purposed of this report as an array of services for children and adolescents to meet their individual needs. An internal workgroup of Department Staff from the Offices of Mental Health, Mental Retardation and Substance Abuse identified the a "recommended" continuum of care for meeting the mental health, mental retardation and substance abuse needs of the children, adolescents and families of Virginia. The array of services in a continuum of care determined by Beth Stroul in a *System of Care Framework* was utilized to determine the best fit for the specific needs of Virginia. The continuum includes the specific services that are provided under the broad dimension areas of mental health, mental retardation and substance abuse services.

COMMUNITY SERVICES	OUT-OF-HOME/RESIDENTIAL
Prevention	
Early Intervention/Intervention	Therapeutic Foster Care
Crisis/Emergency	Therapeutic Group Care
Assessment	Therapeutic Camp
Outpatient Treatment	Independent Living
Home-Based Services	Crisis Residential
Day Treatment	Inpatient Hospitalization
Family Support	

The continuum of care array is divided into services that are provided while the child is in the home (or a home-like) environment, and out-of-home services. A child or adolescent will utilize those services within

the array that best fits his or her need. The full service array is needed to adequately serve the mental health, mental retardation and substance abuse service needs of children, adolescents and their families.

Specialized and supportive services fall under the categories listed in the recommended continuum of mental health, mental retardation and substance abuse services for children, adolescents and their families. Supportive services such as transportation, advocacy, legal services and self-help groups augment the service array. Additional services, which would be included within the categories of the services above, are designed specifically for special population needs, such as for children with developmental delays, and services for children zero to three years of age. Examples of services that would also support the recommended service array, depending on the need of the child, adolescent and/or family are:

- Assistive technology
- Audiology
- Family training, counseling and home visits
- Health services
- Medical services
- Nursing services
- Nutrition services
- Occupational therapy
- Physical therapy
- Psychological services
- Respite care
- Speech-language pathology
- Vision services

An essential service for all the services in the continuum of care is case management. Effective case management services ensure the child, adolescent and family's easy and efficient navigation of the mental health, mental retardation and substance abuse services system. The continuum of mental health, mental retardation and substance abuse services for children, adolescents and their families in Virginia is listed in **Appendix F** of this report. At each Community Service Board, there are different levels and intensities of these services, according to community needs and other variables. A comprehensive needs assessment of what is currently being provided against what is needed by the children, adolescents and their families in Virginia will need to be completed in order to fully address and implement the recommended continuum of these services in an effective manner that will provide and improve access by children, adolescents and their families to needed services.

The recommendations from the services workgroup to the 329-G Planning Group were as follows:

- Continue to support statewide suicide prevention activities.

- Continue to support intensive "family focused" case management services for pregnant, parenting, and at-risk substance-using women and their families.

- Promote prevention activities, as related to early childhood development issues.

- Look at utilizing a comprehensive, uniform instrument for assessment and data collection across all agencies from time of entry into system.

- Support dissemination of Bright Futures mental health module to health care professionals.

- Increase the number of therapeutic day treatment providers.

- Support the Department's policy on transition services by strengthening interagency participation in transition planning and identifying strategies to support interagency collaboration at the state and local levels.

- Move toward an integrated case management system that integrates all information about children and adolescents with mental health, mental retardation, and substance abuse issues and ensures that interventions are planned and coordinated to meet the multiple needs of the child and those systems serving the child and his/her family.

Comprehensive Services Act Workgroup (CSA)

> **"The plan shall examine funding restrictions of the Comprehensive Services Act which impede rural localities from developing local programs for children who are often referred to private and residential treatment facilities for services and make recommendations regarding how rural localities can improve prevention, intervention, and treatment for high-risk children and families, with the goal of broadening treatment options and improving quality and costs effectiveness"....**
>
> -Excerpt from 329-G Budget Language

As indicated in the Report of the Secretary of Health and Human Resources entitled "A Plan for Improving Services and Containing Costs in the Treatment and Care of Children Under the Comprehensive Services

Act for At-Risk Youth and Families", there has been ongoing concern about the limited amount of data available on children served through the Comprehensive Services Act. Further, this issue has complicated the task, according to the report, of projecting caseloads, service needs and costs for the Comprehensive Services Act program. In the 1998 "Review of the Comprehensive Services Act", conducted by the Joint Legislative Audit and Review Commission (Senate Document 26, 1998 General Assembly Sessions), the spending patterns of localities were examined. The examination determined that localities did not spend their allocated funds on non-mandated youth because of the fiscal strain caused by rapidly rising Comprehensive Services Act costs and the obligation to first provide services to mandated youth. The report indicated the localities that did not spend their allocation for non-mandated youth were primarily located in rural areas of the state such as Southwest Virginia, the Shenandoah Valley, the Middle Peninsula, the Northern Neck and Southside Virginia.

The CSA workgroup examined the funding restrictions limiting the ability of rural areas to develop new programs. The group identified issues and sought additional feedback from the community to verify the workgroup member's thoughts about this issue. A forum was held with a group of professionals in the Northwest area of the state for this purpose. The forum assisted the workgroup in validating issues relevant to the budget language, and also helped them craft their recommendations for future work and next steps.

Some selected funding restrictions of CSA that limit the ability of rural areas in developing new programs, according to the forum held in Northwestern Virginia were as follows:

- The funding is for individual clients only.
- The funding cannot be used to start programs or to hire personnel.
- The amount of money available for administrative costs for new programs is not enough to cover the costs of starting a new program in a new locality.
- Those served most often by CSA are in foster care and those in private day or residential programs for special education purposes. Other populations are not generally served through this funding source.
- CSA localities have funds for use with non-mandated populations, but the localities have to provide matching funds for them and as a result many localities choose not to use these funds or provide services to non-mandated youth.
- Rural localities do not develop local programs for youth which results in youth being sent to residential programs out of their community or out of state.

- Rural communities indicate difficulty developing programs for one or two youth. It is a matter of an "economy of scale".

The recommendations from the CSA workgroup to the 329-G Planning Group were as follows:

- Explore revision of CSA procedures to allow the use of CSA funds as program development funds for program development specific to population need.

- Develop incentives for program development similar to those provided in the "Youth In Need of Out-of-Home Placement Study", that directed the DMHMRSAS and the DJJ to create opportunities for public-private partnerships and the necessary incentives to establish and maintain adequate residential beds for the treatment of juvenile offenders with mental health needs.

- Explore the provision of new funds for front-end services, especially related to early intervention and prevention services.

- Reverse funding formulas by allocating higher percentages of identified allocations to specific rural localities to use for program development. Many of the formulas used are based on a population rate, as opposed to service capacity and service need of the locality. These funds need to be flexible according to the locality's needs so that programming can be developed that is consistent with the needs of the population.

Administrative and Services Structure Workgroup

"The plan shall identify the strengths and weaknesses of the current services delivery system and administrative structure"...

-Excerpt from 329-G Budget Language

The administrative and services structure workgroup focused on developing recommendations that would most positively effect and improve access by children and families to mental health, mental retardation and substance abuse services in Virginia. A major theme of this group was the immediate need to increase awareness of existing services and existing resources available in respective localities. The recommendations of the Administrative and Services Structure Workgroup were as follows:

- Examine the feasibility of a single state structure with a mission of serving children and families.

- Interim steps:
  - ❖ Develop Memorandums of understanding (MOUs) to address policy development and coordination of service delivery and procedures between agencies.
  - ❖ Establish a structure for interagency planning, needs assessment and budget development.
  - ❖ Explore the feasibility of developing data collection and outcome measures collected through a data management and information system to reduce paperwork burden and ultimately increase access to services by children and families.
  - ❖ Pilot demonstration projects in several localities, that will provide evaluation and outcome data on proposed service model and integrated system components, evaluate and assess for feasibility of statewide implementation.

- o Develop an interactive web-based resource system designed to improve access/provide information to consumers and families.

- o Explore the development of a "Center of Excellence" that incorporates program development, shared funding, and program evaluation.

- o Develop policy to enable the improvement of the services delivery system through funding targeted toward building program capacity and program start-ups to meet the needs of children with mental health, mental retardation and substance abuse service needs and their families.

<u>Costs and Funding Workgroup</u>

"The plan shall identify the costs and sources of the funding for the services"…

-Excerpt from 329-G Budget Language

This group is working on a survey process that will gather fiscal information that is reliable and useful in designing and improving the funding system for mental health, mental retardation and substance abuse services for children, adolescents and their families. The information gathering from this survey will help support and identify funding capacities for future activities related to recommendations in this report.

The recommendations from the costs and funding workgroup to the 329-G Planning Group were as follows:

- Gain endorsement from the Secretary of Health and Human Resources for survey components and design currently being developed.
- Conduct the survey in an interview format, under supportive correspondence from the Secretary of HHR.
- Analyze and compile survey results to fit with the final recommendations from the remaining three workgroups.
- Allocate new legislative funds to address service gaps and other recommendations.

RECOMMENDATIONS

In April 2003 the 329-G Planning Group convened to review the recommendations of each workgroup. In addition, the final recommendations for this report were developed, posted and feedback was solicited from the group.

Recommendation 1

DMHMRFSAS should request a budget initiative to fund an integrated continuum of mental health, mental retardation and substance abuse services for children, adolescents and their families. The budget initiative shall give consideration to the varying geographic needs in Virginia, filling identified gaps, addressing co-occurring disorders and the needs of special populations such as children with early development needs, young juvenile sex offenders, and adolescents in need of transitional services into the adult services system.

Recommendation 2

The DMHMRSAS should request a budget initiative to fund a determined number of dedicated integrated case managers for children and families all community service boards/behavioral health authorities.

Recommendation 3

The DMHMRSAS should explore existing resources within state and federal funds to provide statewide training on mental health, mental retardation and substance abuse services and in integrated case

management as related to the recommended continuum of mental health, mental retardation and substance abuse services for children, adolescents and their families. All agencies within the Secretariats of Education, Health and Human Resources and Public Safety shall cooperate in the planning and funding of the training.

Recommendation 4

A. The DMHMRSAS, in conjunction with Community Service Boards and Behavioral Health Authorities, should request a dedicated pool of flexible funds to be used specifically for program start-ups and program development, allocated in a manner that maximizes flexibility in program design and promotes achieving specific outcomes for children, adolescents and their families with mental health, mental retardation and substance abuse needs.

B. DMHMRSAS, in conjunction with Community Service Boards and Behavioral Health Authorities, should establish a cooperative agreement with a state university to evaluate the efficiency of such programs based on terms established by the DMHMRSAS.

Recommendation 5

DMHMRSAS should establish an integrated organizational unit that merges existing staff providing child, adolescent and family services into one unit. This organizational unit shall report to the Division Director of Community Programs. The unit should provide leadership for child and family issues on a statewide basis through coordination of services delivery and integration of disability service systems, with the goal of improving access to mental health, mental retardation and substance abuse services for children, adolescents and families in Virginia.

Recommendation 6

DMHMRSAS should establish a state advisory committee for child and family services to support activities of the organizational unit in Recommendation 5.

Recommendation 7

DMHMRSAS should seek ways to build and link the network of parents of children and adolescents with mental health, mental retardation and substance abuse service needs.

Recommendation 8

DMHMRSAS should create, publish and fund an interactive website to be used as a resource for children, adolescents and families to enable improved access to mental health, mental retardation and substance abuse services, providers, educational resources and supports.

NEXT STEPS

Identified next steps would include broad support for moving forward, and operationalizing the final recommendations in order that Virginia's 329-G Policy and Plan may move from being a written idea to an implemented reality and plan that meets the needs of children and adolescents with mental health, mental retardation and substance abuse issues and their families. The time is right to move forward and support this most important and needed system change strategy for Virginia.

The role of the 329-G Planning Group will be in an advisory capacity beginning July 1, 2003. The DMHMRSAS would like to request feedback on the final recommendations contained within this report from the House Appropriations and Senate Finance Committees, so that the implementation of the plan can begin with the endorsement of those entities.

It is anticipated that the components identified within this report and supporting the final recommendations would be placed into a work-plan developed by the DMHMRSAS within the first quarter of SFY '04. Implementation activities would begin in the second quarter of SFY '04 and continue forward as appropriate.